REQUIREMENTS FOR PATIENT CARE RECORDS

PURPOSE

To delineate requirements within the ICEMA region regarding the initiation, completion, review and retention of patient care report forms.

AUTHORITY

Title 22, California Administrative Code, Sections 1000168(6) (A-D) and 100085(6) (f).

PRINCIPLE

The patient care report form in the ICEMA region shall be comprised of a narrative patient care report form (ICEMA approved patient care report form or approved electronic Patient Care Report) and an ICEMA approved data collection device. They will be initiated each time an EMS unit is dispatched by an EMS service provider, where the outcome of the call results in patient assessment with or without service or treatment by the EMS provider.

In situations where more than one (1) patient is encountered at the scene of an incident, one (1) set of patient care record forms shall be initiated for each patient.

In the event that two (2) EMS provider agencies arrive on scene at an incident, each EMS provider having actual contact with a patient is responsible for completing a patient care report form and obtain all ICEMA required data containing an incident number and patient identification information and record those assessments, services or treatments delivered by the EMS provider completing that form. Thus, a patient receiving initial BLS level service followed by ALS treatment by another provider agency would have two (2) sets of EMS forms.

RESPONSIBILITIES FOR RECORD COMPLETION

Each set of EMS patient care record forms shall be completed as specified in the 'EMS Run Report Form Completion Instructions", which serves as an extension to this policy. Each EMS patient care provider is responsible for proper completion of patient care records. Additional responsibility for accurate and thorough completion of patient care records lies with the EMS provider agency.

EMS providers who fail to thoroughly complete patient care records according to this policy will be given an opportunity to correct errors and/or omissions, following EMS review of the form as initially submitted.

In the event that addition(s) are required to a narrative patient care record form after submission of that form to the receiving hospital, a separate, new narrative patient care record form must be completed in full with one (1) copy forwarded to the receiving hospital and one (1) copy to EMS. Correction(s) to a Scantron form are to be made on the original Data Sheet whenever possible, and corrected Data Sheets sent to EMS in batches clearly marked as "corrections".

RESPONSIBILITIES FOR RECORD RETENTION

Requirements

1. All records related to either suspected or pending litigation shall be held for an indefinite period of time.

2. The patient care records of all patients other than un-emancipated minors shall be retained by the respective agencies for a minimum of seven (7) years.

3. The records of un-emancipated minors shall be kept for at least one (1) year after such minors have reached the age of 18, but in no event less than seven (7) years following the provision of service to the minor.

4. All receiving hospital copies of the patient care record form shall accompany the patient to the receiving hospital and be retained by the receiving hospital for a minimum of one (1) year in the patient's medical record.

5. The EMS service provider agency shall be responsible for retention of the provider copy of the patient care record form.

Types of Records for Retention

1. The Base Hospital information form for each Base Hospital advanced life support radio contact.

2. Labeled tapes (not transcriptions) or other type hard copies of communications between advanced life support personnel and the Base Hospital physician and/or MICN.

3. Chronological log of each Base Hospital advanced life support radio contact.

4. Patient care records.

RESPONSIBILITIES FOR RECORD REVIEW AND EVALUATION

ICEMA may request a copy of any completed patient care record form. Responsibility for timely submission of requested forms lies with the EMS service provider agency.

Designated ICEMA staff shall be responsible for reviewing all completed patient care record forms submitted to ICEMA. Such review shall include, but not be limited to, procedures to determine the completeness of forms, methods to collect data recorded on the EMS copies of forms, and processing to produce statistical and quality assurance summary reports.

Evaluation of statistical summary reports shall be the responsibility of the ICEMA Executive Director. Evaluation of medical quality assurance summary reports shall be the responsibility of the ICEMA Medical Director. Copies of statistical summary and QA summary reports will be provided to provider agencies upon request.